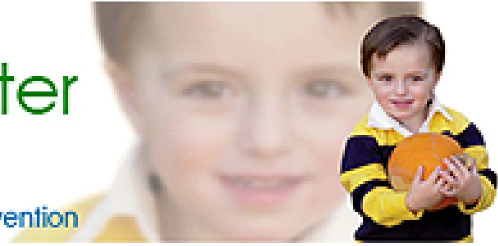
Alta Vista Center
for Autism
The Art and Science of Effective Intervention



Admission Packet

- ☐ **Medical Release Form**
- ☐ **Pick-Up Authorization**

Revised
22 February 2008

MEDICAL RELEASE FORM

Client name ____DOB________________

Address____

Parent(s)/Legal Guardian(s) ____

Home Phone____________________

Parent/Guardian 1 work phone____________________ Parent/Guardian 1 cell phone ____________________

Parent/Guardian 2 work phone____________________ Parent/Guardian 2 cell phone____________________

Emergency Contact 1 (other than parent) ______________________________________

Address ____

Phone_________________________Relationship___________________________

Emergency Contact 2 (other than parent) ______________________________________

Address ____

Phone_________________________Relationship___________________________

Diagnosis____

Allergies (Food/Other) ____

Seizures? Y or N; Type/Description ____

Medications/Dosages/Time Given ____

____

Other special medical needs: ____

____

Physician name, address, phone ____

____

Dentist name, address, phone ____

____

Hospital Choice name, address, phone______________________________________

____

Insurance Company/Policy Holder/Number ___________________________________

Are immunizations up to date? Y or N **Please submit immunization record or proof of exemption.**

I, parent/legal guardian of the above named child, authorize trained staff members of the Alta Vista Center to monitor and administer medication(s) per my above written directions. It is my responsibility to notify the staff, in writing, of any changes in medications, dosages, administration times, or procedures.

I, parent/legal guardian of the above named child, authorize the staff of the Alta Vista Center to act in my behalf in case of accident, injury or illness when immediate medical or surgical care is needed provided the above named individual makes a diligent effort to first notify me of the situation are unsuccessful, I authorize the above named individual to take necessary action and give consent on my behalf as his/her judgment dictates.

Medical Responsibility: I further agree to assume financial responsibility in the event of accident, injury or illness of my child while in the care of The Alta Vista Center. If I cannot be reached, I hereby give permission to the above named individual to sign hospital operative permits for my child for such operations or dental procedures as are considered necessary or desirable by medical judgment, including administration of anesthesia.

______________________________ ____________________

Parent/Legal Guardian Signature Date

____

Printed Name

This release expires three years from date of signature

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PICK-UP AUTHORIZATION

I, ___________________________, authorize the persons listed below to pick up my child/ward, ______________________________, from The Alta Vista Center for Autism. I understand that only the persons listed below will be allowed to pick up my child. Following delivery of this document to the Alta Vista Center, all additions to this list must be done by me, or another legal guardian, ***in person only***.

_______________________________________ Parent/Guardian Signature

_____________________________________ Date

Name & Relationship to child	Driver's License #	Address	Phone Number